M00R
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change	% Change Prior Year
Special Fund	$155,830	$162,140	$174,958	$12,818	7.9%
Contingent & Back of Bill Reductions	0	0	-12	-12	
Adjusted Special Fund	**$155,830**	**$162,140**	**$174,946**	**$12,806**	**7.9%**
Federal Fund	3,885	2,800	927	-1,873	-66.9%
Adjusted Federal Fund	**$3,885**	**$2,800**	**$927**	**-$1,873**	**-66.9%**
Reimbursable Fund	5,075	1,483	0	-1,483	-100.0%
Adjusted Reimbursable Fund	**$5,075**	**$1,483**	**$0**	**-$1,483**	**-100.0%**
Adjusted Grand Total	**$164,789**	**$166,424**	**$175,873**	**$9,449**	**5.7%**

- Deficiency appropriations add $1.1 million to the Maryland Health Care Commission (MHCC) to cover costs associated with the Small Employer Health Benefit Premium Subsidy Program and the patient centered medical home program and $11.0 million to the Health Services Cost Review Commission (HSCRC), primarily for uncompensated care payments.

- The fiscal 2014 budget for the regulatory commissions increases by $9.4 million, 5.7%, over the fiscal 2013 working appropriation. However, adjusted for fiscal 2013 deficiency appropriations, the fiscal 2014 budget is $1.7 million (0.9%) lower than the revised fiscal 2013 appropriation.

Note: Numbers may not sum to total due to rounding.

For further information contact: Simon G. Powell Phone: (410) 946-5530

Personnel Data

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change
Regular Positions	98.70	98.70	98.70	0.00
Contractual FTEs	0.00	0.35	0.00	-0.35
Total Personnel	**98.70**	**99.05**	**98.70**	**-0.35**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	5.70	5.77%
Positions and Percentage Vacant as of 12/31/12	12.00	12.16%

- There are no new positions for the regulatory commissions in fiscal 2014.
- The fiscal 2014 budget includes significant funding for reclassifications in MHCC.

Analysis in Brief

Major Trends

Electronic Data Exchange: Progress continues to be made in increasing the percent of claims paid electronically by private payors.

Small Group Market: The Comprehensive Standard Health Benefit Plan became less affordable in fiscal 2012.

Medicare Waiver: The most recent estimates from HSCRC illustrate continued pressure on the Medicare waiver cushion. Negotiations with the federal government to modernize Maryland's unique hospital rate-setting system remain ongoing.

Issues

Implementation of Health Enterprise Zones: One year after legislation creating Health Enterprise Zones (HEZ) in Maryland was debated and passed, the initial HEZs were designated.

Recommended Actions

		Funds
1.	Reduce funding for the Small Employer Health Premium Subsidy.	$ 1,000,000
	Total Reductions	**$ 1,000,000**

M00R
Health Regulatory Commissions
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Health Regulatory Commissions are independent agencies that operate within the Department of Health and Mental Hygiene (DHMH). The agencies variously regulate the health care delivery system, monitor the price and affordability of services offered in the industry, and improve access to care for Marylanders. The three commissions are the Maryland Health Care Commission (MHCC), the Health Services Cost Review Commission (HSCRC), and the Maryland Community Health Resources Commission (MCHRC).

MHCC, formed by the 1999 merger of the Health Care Access and Cost Commission and the Health Resources Planning Commission, has the purpose of improving access to affordable health care; reporting information relevant to availability, cost, and quality of health care statewide; and developing sets of benefits to be offered as part of the standard benefit plan for the small group market. The commission's goals include:

- improving the quality of care in the health care industry;
- improving access to and affordability of health insurance, especially for small employers;
- reducing the rate of growth in health care spending; and
- providing a framework for guiding the future development of services and facilities regulated under the certificate of need program.

HSCRC was established in 1971 to contain hospital costs, maintain fairness in hospital payment, and provide financial access to hospital care. The commission maintains responsibility for ensuring that the cost of health care is reasonable relative to the cost of service and that rates are set without discrimination. The commission's goals include:

- maintaining affordable hospital care for all Maryland citizens;
- expanding the current system for financing hospital care for those without health insurance; and
- eliminating preferential charging activity through monitoring of hospital pricing and contracting activity.

MCHRC was established in 2005 to strengthen the safety net for uninsured and underinsured Marylanders. The safety net consists of community health resource centers (CHRC), which range from federally qualified health centers to smaller community-based clinics. MCHRC's responsibilities include:

- identifying and seeking federal and State funding for the expansion of CHRCs;
- developing outreach programs to educate and inform individuals of the availability of CHRCs; and
- assisting uninsured individuals under 200% of the federal poverty level to access health care services through CHRCs.

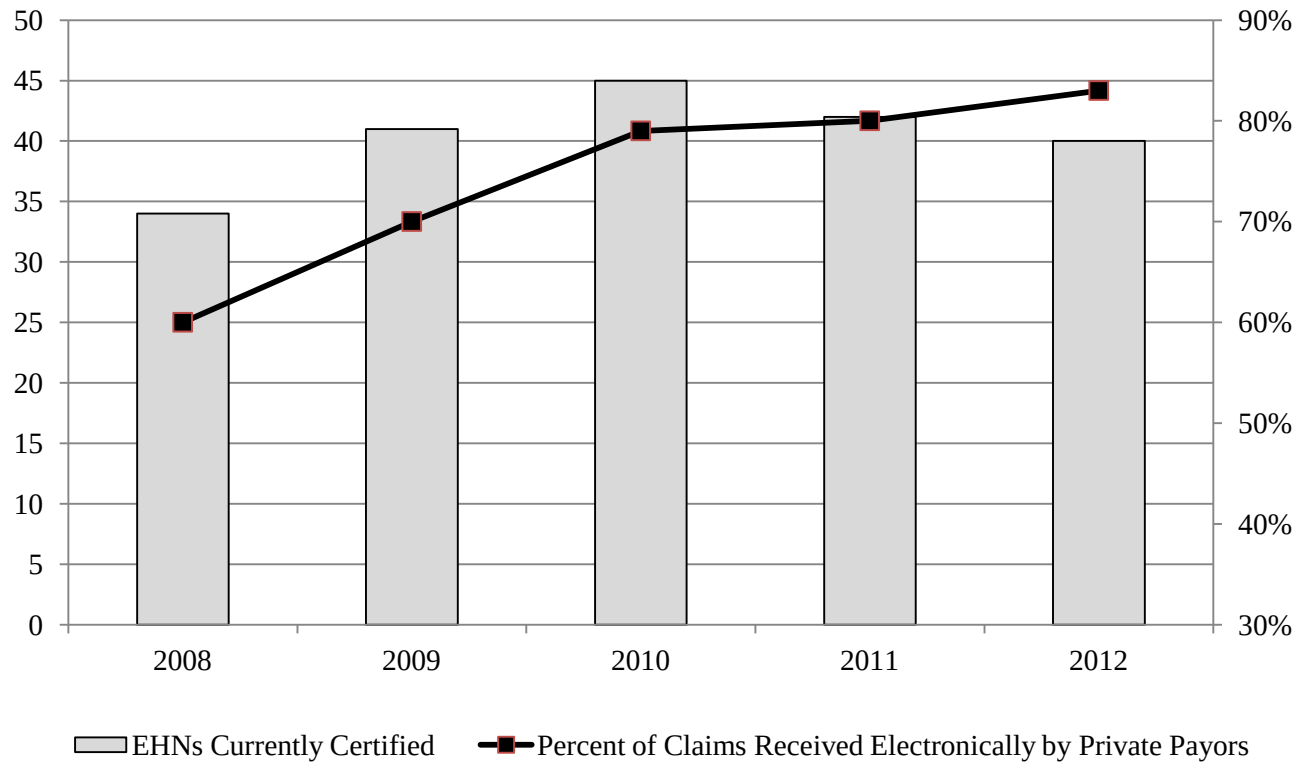
Performance Analysis: Managing for Results

1. Electronic Data Exchange

One of the goals of MHCC is to reduce the rate of growth in health care spending in Maryland. One strategy to lower costs is eliminating unnecessary administrative expenses through the adoption of electronic data exchange. There are two main strategies used by the commission to achieve this goal: (1) developing programs that encourage the adoption of health information technology (IT); and (2) certifying electronic health networks (EHN) that provide for the electronic exchange of payment information between Maryland health care payors and providers. **Exhibit 1** shows the number of EHNs currently certified by MHCC and the percent of claims received electronically by private payors in Maryland.

As shown in the exhibit, the number of EHNs in the State, which had been steadily increasing since fiscal 2008, actually fell in fiscal 2011 and 2012. However, according to MHCC, several EHNs consolidated, reducing the total number of certified EHNs. Nevertheless, the percent of claims paid electronically by private payors continued to increase in fiscal 2012, up to 83%.

Exhibit 1
Utilization of Electronic Health Networks in Maryland
Fiscal 2008-2012



EHN: electronic health network

Source: Department of Health and Mental Hygiene

2. Small Group Market

Exhibit 2 presents data on the small group market. Specifically, the exhibit shows that the percentage of small employers in Maryland offering coverage, which had fallen to 35% in fiscal 2011, stayed at that level in fiscal 2012. Given the recent recession, this comes as no surprise. Under current law, the average premium of the Comprehensive Standard Health Benefit Plan must amount to no more than 10% of Maryland annual average wage – the so-called affordability cap. As shown in Exhibit 2, the average plan cost 98% of the affordability cap in fiscal 2012. This jump continues to reflect the additional costs associated with conforming Maryland's insurance products to federal mandates required under the Patient Protection and Affordable Care Act (ACA).

Exhibit 2
Small Group Market – Various Data
Fiscal 2008-2012

	2008	2009	2010	2011	2012
Percent of Small Employers Offering Coverage	41%	39.6%	38%	35%	35%
Average Cost of Plan as Percent of Affordability Cap	93%	85%	88%	95%	98%

Note: Data reported in the Managing for Results for the affordability gap in fiscal 2011 and fiscal 2012 are 88%. The data shown here is updated data from the Maryland Health Care Commission.

Source: Department of Health and Mental Hygiene

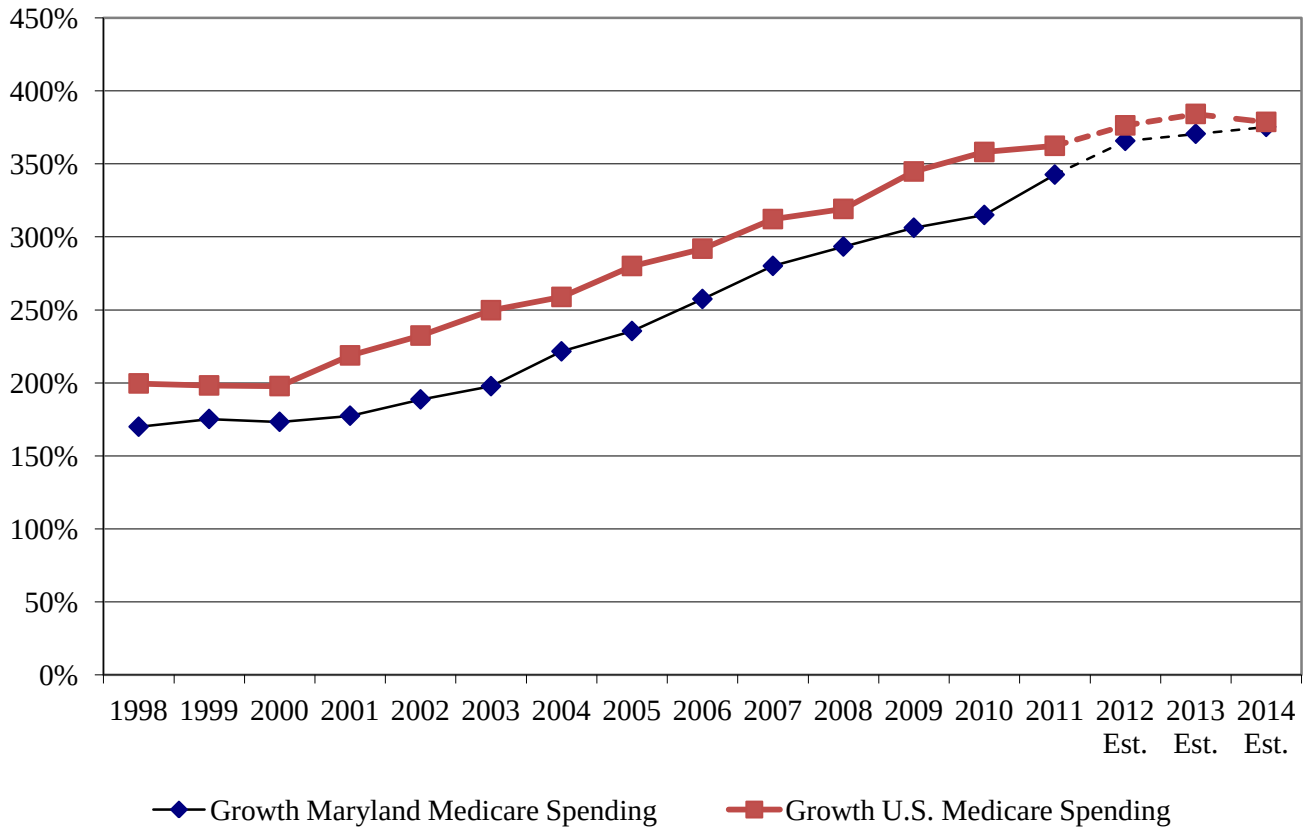
3. Medicare Waiver

HSCRC sets standard rates that hospitals may charge for the purchase of care. This system encourages access to health care regardless of ability to pay and prevents cost shifting between payors. The commission's ability to standardize rates for all payors, including Medicare and Medicaid, was established in 1980 by federal legislation, with continued regulatory authority contingent on the commission's ability to contain the rate of growth of Medicare hospital admissions costs.

Growth of Medicare Payments

In order to maintain an all-payor system, Maryland must contain the cost of health care such that the growth of Medicare payments does not surpass the growth of Medicare nationally. **Exhibit 3** illustrates the actual growth of Medicare spending between fiscal 1998 and 2011 plus projections through fiscal 2014. The exhibit shows that the rate of growth in Maryland remains below the national average. As of June 2011, the cumulative growth of Maryland Medicare payments has been 342.61%, compared to national growth of 362.34%. However, also shown in the exhibit, projections developed by HSCRC and its actuaries suggest a significant narrowing of this gap in fiscal 2012 and 2013. By fiscal 2014, assuming a 0.0% fiscal 2014 update factor and the imposition of Medicare cuts at the federal level as currently outlined in sequestration, the gap is virtually closed.

Exhibit 3
Medicare Payments Growth: Maryland vs. National Average
Fiscal 1998-2014

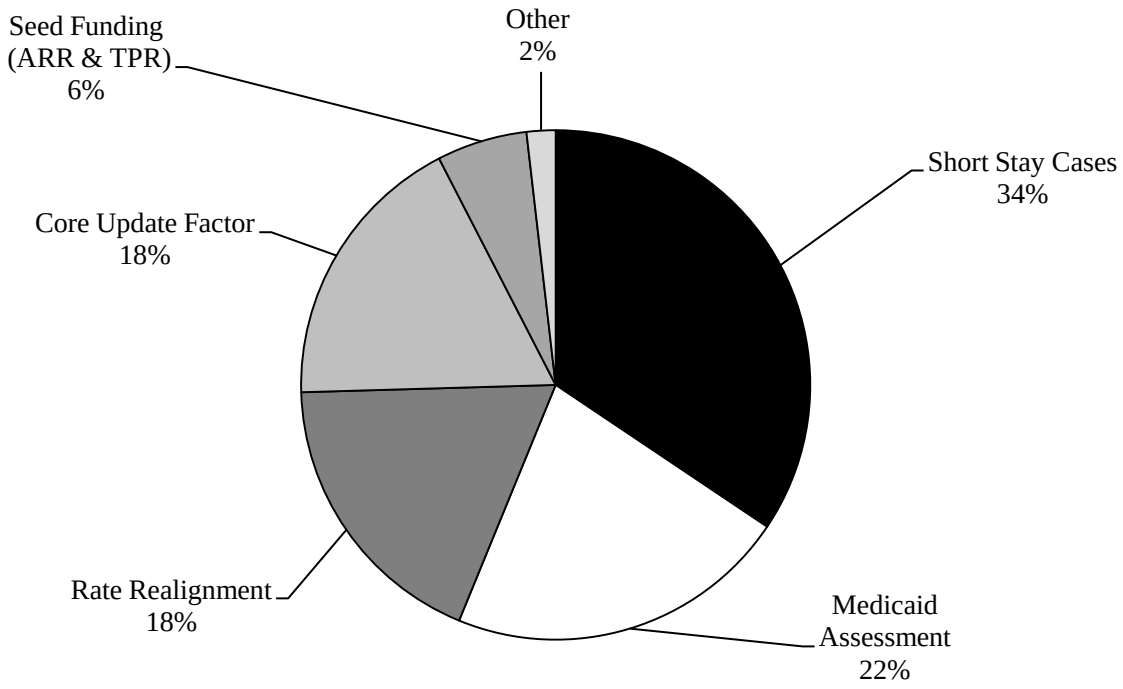


Note: Fiscal 2012 through 2014 are estimates. The fiscal 2014 estimate is based on a 2% Medicare payment cut through federal sequestration (current law) and a 0% hospital update factor.

Source: Department of Health and Mental Hygiene

As shown in Exhibit 3, between fiscal 2010 and 2011, Medicare payment growth in Maryland grew by 8.8%, compared to only 1.2% nationally. HSCRC, looking at a slightly different timeframe (the year ending February 2012), noted that the average charge per case grew by 8.69%. The major causes of charge per case growth are provided in **Exhibit 4** and include:

Exhibit 4
Factors Contributing to Charge per Case Growth
Year Ending February 2012



ARR: Admission-Readmission Revenue
TPR: Total Patient Revenue

Note: Total charge per case growth in the period was 8.69%.

Source: Department of Health and Mental Hygiene

- The policy for one-day stays (34.0%). Specifically, in an effort to limit what it saw as an over-utilization of short stays, HSCRC excluded inpatient stays of less than 24 hours from the charge per case methodology. The commission reasoned that the overuse of inpatient services for medical and surgical cases arguably inflates the overall cost of hospital care in Maryland and that there was evidence to suggest that there may be negative quality of care implications with excessive inpatient treatment.

- Funding for the Medicaid hospital assessment (22.0%).

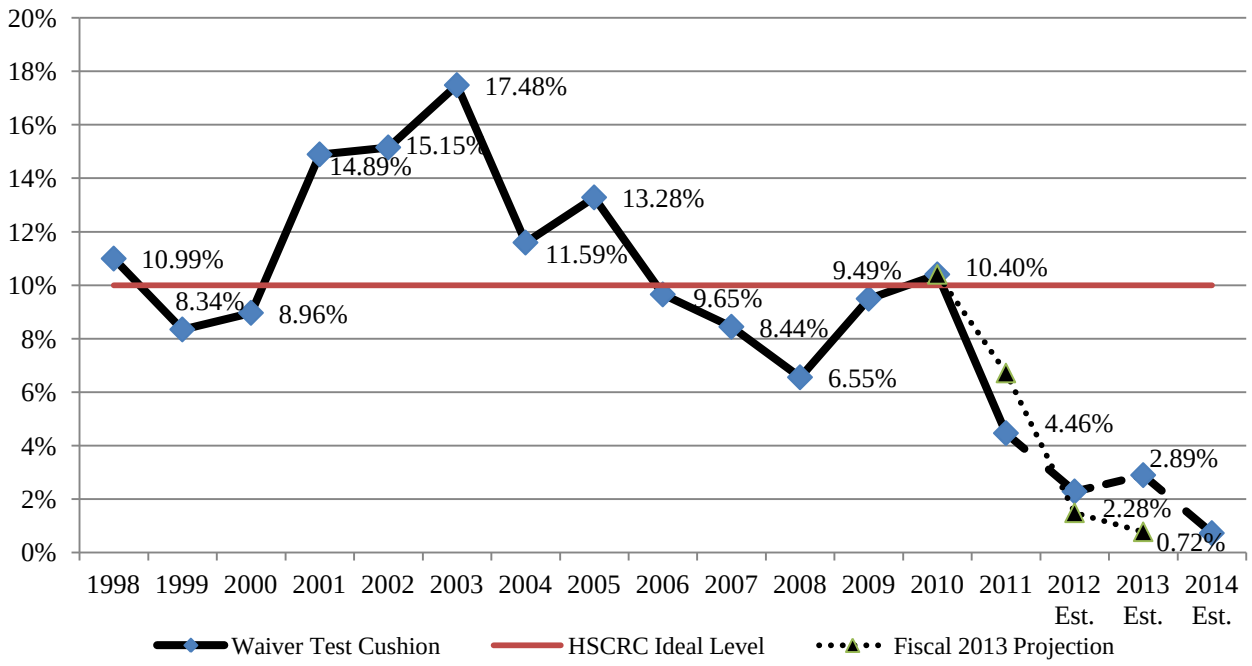
- Rate realignment that resulted in increased inpatient revenues (18.0%).

- The hospital update factor (18.0%).

Waiver Cushion

This narrowing of the gap between cumulative Maryland and U.S. Medicare growth rates is also reflected in the primary measure used to monitor waiver performance, namely the relative waiver margin calculation, a test performed using an independent economic model that assumes a flat rate of growth in Medicare payments per case. The result of the test is the relative waiver margin or "waiver cushion," which represents the amount Medicare payments to Maryland could grow, assuming zero growth in Medicare payments nationally, before the State failed to meet its waiver requirements. HSCRC has determined that 10.0% is the lowest desirable level for the waiver margin; however, a margin between 12.0 to 15.0% is ideal. The larger the margin, the more flexibility HSCRC has to adjust rates while simultaneously weathering Medicare payment trends. As shown in **Exhibit 5**, over the past decade, the waiver cushion has fluctuated either side of the 10.0% desirable level. Information on the national average has an 18-month lag, so the most current actual data is from the end of fiscal 2011. The cushion shrank from 10.4% at the end of fiscal 2010 to 4.46% at the end of fiscal 2011.

Exhibit 5
Medicare Waiver Cushion
Fiscal 1998-2014



HSCRC: Health Services Cost Review Commission

Note: Data shown are values/estimates for the end of each fiscal year. Fiscal 2012 through 2014 estimates are estimates. Fiscal 2014 estimate is based on a 2% Medicare payment cut through federal sequestration (current law) and a 0% hospital update factor.

Source: Department of Health and Mental Hygiene

As also shown in Exhibit 5, this steep decline between fiscal 2010 and 2011 was actually greater than projected by HSCRC at the time of fiscal 2013 budget deliberations (the projection for fiscal 2011 was for a 6.71% margin).

The projection developed during the 2013 session indicated that the waiver margin would erode to 1.48% at the end of fiscal 2012 and 0.77% at the end of fiscal 2013. As shown in Exhibit 5, HSCRC was able to take a series of short-term actions to marginally improve the waiver cushion. In March and June 2012, HSCRC approved:

- realignment of revenues between inpatient and outpatient hospital settings to capture changes in patterns of care not reflected in cost reports used to develop fiscal 2012 rates;

- suspension of the charge per visit methodology, which limited the rate of increase in the revenue per outpatient visit on the condition that a new or revised outpatient constraint system be implemented by fiscal 2014;

- inclusion of one-day stay cases in the calculation of case mix (a measurement of each hospital's average patient acuity) for fiscal 2012; and

- in June 2012, a net increase in hospital revenues of 0.3% for fiscal 2013, which included a 1.0% cut to impatient rates aimed at improving waiver performance and a 2.59% increase in outpatient rates.

Renegotiating the Waiver

While these emergency actions have resulted in marginal improvement in anticipated waiver performance, in the long term, State officials and stakeholders recognize the need to modernize the State's waiver test. According to HSCRC, the drive for efficiency in health care has shifted from seeking to reduce resource use within an individual hospital stay to managing episodes of care across multiple settings with additional focus on prevention and population health. HSCRC has adopted rate-setting methodologies to encourage improved provision of services across settings by reducing preventable readmissions and providing capped revenue for hospital services to encourage delivery of care at lower levels of acuity. Unfortunately, these steps are out-of-sync with the existing waiver test and its focus on the average Medicare charge per case payment in Maryland compared with the national average.

To address erosion in the waiver cushion long term, HSCRC has met with payors, DHMH, and hospitals since early 2012 to discuss modernization of the waiver to align the incentives with improved quality, improved population health, and lower growth in the cost of care. The State has announced that it would be seeking Medicare waiver negotiations through the ACA State Innovations Waiver process.

At various points in the 2012 session and again in the interim, DHMH outlined a timeframe for the completion of waiver negotiations before the end of 2012. However, a formal letter of interest

in waiver renegotiation from Governor Martin J. O'Malley to the Health and Human Services Secretary Kathleen Sibelius was not sent until November 1, 2012. Negotiations are still ongoing and the deadline for submission of a final draft proposal to the Centers for Medicare and Medicaid Services (CMS) has now been pushed back to March 1, 2013. Once the final draft is received and accepted by CMS, a federal review process of between two to five months is anticipated.

No specifics as to what will be included in the final draft proposal have been made available. In addition to the overall goals noted above (aligning incentives with quality, improving population health, and lowering the growth in the cost of care), it is anticipated that the new waiver will reward rather than penalize delivery system reforms already underway (for example, Total Patient Revenue in 10 hospitals, bundled payments, and the growth in medical homes). HSCRC has indicated that it is exploring a more holistic approach such as per capita or per-beneficiary spending on a variety of services rather than a sole focus on per-case costs for inpatient stays.

Recommendations have also been proposed by stakeholders including reexamination and realignment of the current governmental differential (Medicare and Medicaid receive a 6% discount on hospital rates) to improve the waiver cushion and reduce Medicaid reliance on hospital assessments; an overhaul of the outpatient pricing system; adoption of case targets and real case mix governors for short stay cases; implementation of more standardized pricing of services among hospitals; reduction of incentives for volume and unnecessary utilization; and alignment of physician incentives with hospital incentives.

HSCRC should be prepared to update the committees on the Medicare waiver discussions.

Fiscal 2013 Actions

Proposed Deficiency

There are two proposed deficiency appropriations for the regulatory commissions. Specifically:

- $1,063,419 in special funds for MHCC. Of this amount, $423,419 is to cover costs associated with the Small Employer Health Benefit Premium Subsidy Program, and $640,000 is for increased costs of the patient centered medical home program.

- $11,023,453 in special funds for HSCRC. Of this amount, $10.9 million recognizes increased funding available for uncompensated care payments with the remainder for HSCRC administrative costs.

Proposed Budget

As shown in **Exhibit 6**, the fiscal 2014 budget for the regulatory commissions is $9.4 million, 5.7%, above the fiscal 2013 working appropriation. However, if the 2013 deficiency appropriations are considered, the budget declines by $1.7 million, 0.9%.

Exhibit 6
Proposed Budget
DHMH – Health Regulatory Commissions
($ in Thousands)

How Much It Grows:	Special Fund	Federal Fund	Reimb. Fund	Total
2013 Working Appropriation	$162,140	$2,800	$1,483	$166,424
2014 Allowance	174,958	927	0	175,885
Amount Change	$12,818	-$1,873	-$1,483	$9,461
Percent Change	7.9%	-66.9%	-100.0%	5.7%
Contingent Reductions	-$12	$0	$0	-$12
Adjusted Change	$12,806	-$1,873	-$1,483	$9,449
Adjusted Percent Change	7.9%	-66.9%	-100.0%	5.7%

Where It Goes:		
Personnel Expenses	**$653**	
Regular earnings		$267
Retirement contributions		259
Employee and retiree health insurance		94
Annualization of fiscal 2013 2% cost-of-living adjustment		88
Reclassifications		65
Miscellaneous adjustments		38
Workers' compensation assessment		23
Social Security contributions		22
Turnover adjustment		-203
Maryland Health Care Commission	**-$1,029**	
Small employer helath benefit premium subsidy		300
Biannual trauma grants		300
Nursing home/hospital guide web re-design		200

Where It Goes:		
Hospital quality monitoring (contract expenses)		129
Health Information Technology initiatives (contract expenses)		105
Data processing charges		70
Patient centered medical home evaluation contract		-260
Health Insurance Exchange Cooperative Agreement (federal funds)		-1,873
Health Services Cost Review Commission	**$10,137**	
Uncompensated care fund		10,000
Monitoring and auditing of hospital performance and finances		137
Maryland Community Health Resource Commission	**-$400**	
Operating grants		673
Unified data system grants		300
Grant evaluation		100
Patient centered medical home support		-100
Developmental disabilities one-time infrastructure grants (reimbursable funds)		-1,373
Other		88
Total		**$9,449**

Note: Numbers may not sum to total due to rounding.

Personnel Expenditures

Personnel expenses across all three commissions are anticipated to increase by $653,000 in fiscal 2014. Regular earnings increase by $267,000 (above and beyond the annualization of the fiscal 2013 cost-of-living adjustment (COLA) which adds a further $88,000). According to DHMH, this is the result of two things:

- Reclassification actions in fiscal 2013 for senior positions in MHCC and HSCRC which result in higher fiscal 2014 salaries compared to that currently reflected in fiscal 2013 data; and

- The filling of vacant positions during the course of fiscal 2013, with those vacant positions listed at the base salary level in fiscal 2013 data but having an actual (higher) salary level in fiscal 2014.

There is additional reclassification funding included in the fiscal 2014 budget ($308,000 in total, and $65,000 more than in fiscal 2013) to support increased salaries across a broad range of positions, all in MHCC. These increases are supported by the findings of a compensation study completed in fiscal 2012 and 2013.

While the commissions have a level of independent salary setting authority in statute, that these reclassifications can occur in these special funded agencies does raise the issue about parity with general funded agencies (and is the reason why agencies often lobby hard for independent salary setting authority and special fund status). Undertaking compensation studies at the State level are generally resisted simply to avoid the likely outcome of those studies. When they are conducted, they are often not implemented except to the extent that a specific job classification may be occasionally identified for salary increases through the annual salary review (ASR) process. By way of contrast, funding for ASRs in the fiscal 2014 budget statewide totals $3.6 million compared to $300,000 for the 61.7 full-time equivalents in MHCC.

The other significant increase to the personnel budget is $259,000 in increased retirement contributions to reflect underperformance of the State retirement system and changing actuarial assumptions. An increase in turnover of $203,000 reflects current vacancy levels.

Maryland Health Care Commission Nonpersonnel Expenditures

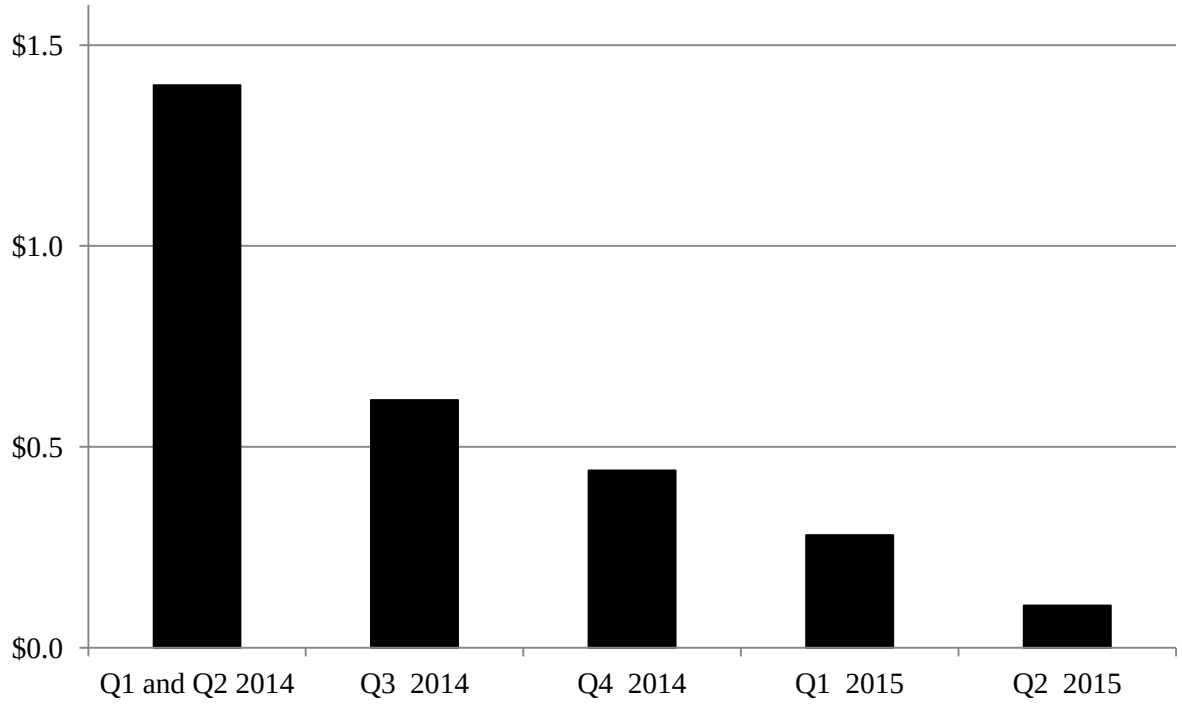
MHCC nonpersonnel expenditures decrease by $1 million in fiscal 2014 from fiscal 2013. As shown in Exhibit 6, significant increases include $300,000 for the Small Employer Health Benefit Premium Subsidy Program. Funding for the program in fiscal 2014 totals $2.6 million. This program, created in the 2007 special session and funded with the averted uncompensated care assessment, assists small businesses in purchasing health insurance for their employees through the Health Insurance Partnership. The program has never lived up to original expectations in terms of the number of business and individuals participating. The program currently serves 422 employers, 1,652 employees, and 1,892 covered lives.

The program is open to businesses with at least two, and no more than nine, full-time employees both at the time of initial application and on at least 50% of its working days during the past calendar quarter; that have not offered insurance to its employees in the most recent 12 months; and the average wage of the full-time employees is below $50,000. Any full-time employee who obtains health insurance through an eligible small employer's plan may receive a subsidy toward the cost of employee-only coverage and under certain conditions for dependent coverage. Subsidies vary according to average wage.

In recognition that businesses eligible for the program will be eligible for tax credits (up to 50%) through the Small Business Health Options Program (SHOP) exchange in the Maryland Health Benefit Exchange (MHBE), MHCC is recommending that the program be phased out by closing the program to new entrants effective January 2, 2014, and discontinuing enrollment at the subsequent renewal date. MHCC argues for this transitional approach versus migrating everybody to the MHBE effective January 2, 2014.

Based on this transitional approach, as shown in **Exhibit 7**, MHCC projects the following funding need for fiscal 2014 and 2015:

Exhibit 7
Projected Need for the Small Employer Health Premium Subsidy
Fiscal 2014-2015
($ in Millions)



Note: Projections from the Maryland Health Care Commission do not include medical inflation for fiscal 2014 and 2015 and assume no growth baseline beyond current levels.

Source: Maryland Health Care Commission

MHCC's arguments in favor of this approach include not wanting to modify benefits in the middle of a plan year, thereby forcing small businesses to think about benefits twice in one year; the potential financial impact of having to satisfy high deductibles twice in one year; the onerous nature of the federal tax subsidy program; and the operational impact on the MHBE. The Department of Legislative Services (DLS) would note that the federal tax subsidies available through MHBE will be significant; MHBE is being allocated adequate resources to accommodate the transition effective immediately, with the enrollment from this program sufficiently small to have only a marginal impact on MHBE; and, most significantly, the State should be rational about maximizing its resources by moving people into MHBE rather than continuing to offer duplicative programs. The opening of MHBE should hardly come as a surprise to any small business and MHCC can easily make those in the current program aware of the need to switch with adequate notice. MHBE is scheduled to be open for enrollment October 1, 2013, allowing time for a smooth transition.

Thus, DLS recommends that the Small Employer Health Benefit Premium Subsidy Program close effective January 2, 2014, reducing the fiscal 2014 budget by $1 million. Reducing special funds will allow for a general fund reduction in the Medicaid program as the special funds supporting this program are statutorily available to Medicaid.

Other increases for MHCC include $300,000 in the Maryland Trauma Physicians Services Fund program. Specifically, every other year, the commission gives grants of up to a value of 10% of the fund's surplus. Fiscal 2013 was an off-year where no grants are awarded. There is also additional funding for a nursing home/hospital guide web redesign ($200,000); contracts related to MHCC's work on hospital quality ($129,000 overall increase including a proposed $350,000 contract for a quality assessment of cardiac services that is offset by declines in other contracts); and a variety of smaller contracts aimed at improving the adoption of health IT in various settings ($105,000).

MHCC's fiscal 2014 budget also sees a significant decrease in contract funding for the evaluation of the patient-centered medical home initiative ($260,000). Patient-centered medical homes are designed to achieve better health outcomes, increase patient satisfaction, and lower *per capita* health care costs. MHCC has a contract for a multi-year evaluation of this initiative and funding, albeit at a lower level than fiscal 2013, remaining in the budget in fiscal 2014.

Additionally, there is a $1.9 million reduction in spending related to the State Health Information Exchange (HIE) Cooperative Agreement. The development of a statewide HIE is designed to create an interconnected, consumer driven, electronic health care system that enables stakeholders to securely share data, facilitate and integrate care, create efficiencies, and improve outcomes. Maryland's HIE is being implemented through the Chesapeake Regional Information System for Our Patients (CRISP). CRISP is funded through a $10.0 million award from HSCRC derived from the all-payor system, as well as federal grants which are budgeted in MHCC. Fiscal 2014 funding for the HIE reflects:

- a decline of $1.3 million for interstate activities plus participation in the nationwide Health Information Network; and

- a drop of $573,000 in federal grant funding related to the integration of certain long-term care facilities into the HIE.

Health Services Cost Review Commission Nonpersonnel Expenditures

The major change for HSCRC is increased funding ($10 million) into the Uncompensated Care Fund. However, as noted above, there is a significant fiscal 2013 deficiency appropriation, which actually slightly reduces available funds in fiscal 2014 compared to 2013. This fund is used to more fully share the costs of uncompensated care between hospitals. Hospitals that have lower than average uncompensated care pay into the fund to reduce uncompensated care for those hospitals with higher than average uncompensated care.

It should also be noted that HSCRC is adding funding to its existing contracts to monitor and audit hospital performance ($137,000). These contracts are intended to ensure that the inpatient and outpatient data submitted by hospitals to the HSCRC are accurate.

Maryland Community Health Resources Commission Nonpersonnel Expenditures

Funding for MCHRC shows a $400,000 reduction in fiscal 2014 compared to 2013. Funding support from the MCHRC's special fund, which is derived from the CareFirst premium tax exemption, increases by $1.0 million to $8.0 million to reflect the fiscal 2014 statutory funding amount for MCHRC, an amount established by Chapter 397 of 2011 (the Budget Reconciliation and Financing Act (BRFA) of 2011). Offsetting this increase in special funds is a $1.4 million reduction of reimbursable funding from the Developmental Disabilities Administration (DDA).

The additional special funding is distributed between support for operating grants ($673,000) and data system grants ($300,000).

- The operating grants are made through a request for proposals (RFP) process to community health resource centers (for example, local health departments, federally qualified health centers, community clinics, school-based health centers, and other providers) to increase access to care for uninsured and underinsured individuals. The available funding in fiscal 2014 restores funding for these grants to just above the level available in fiscal 2010.

- The data system grants are also made through an RFP process to community health resource centers to improve efficiency through the adoption of technology. The available funding in fiscal 2014 represents a significant increase in funding for this area of grants over that provided in recent years.

The MCHRC budget also increases funding for consultants to aid the commission in reviewing applications for its available grant funding ($100,000). This funding was cut in fiscal 2013. Offsetting this increase is a $100,000 reduction in funding for support of MHCC's patient centered medical home initiative.

As noted above, the most significant drop in funding is $1.4 million in reimbursable funds from DDA. This funding was part of a fiscal 2012 transfer of funds from DDA to MCHRC for the provision of one-time grants to providers. At the time, this funding was deemed surplus in DDA; in reality, DDA ended up with a fiscal 2012 deficit ironically close to the level of the transfer made to MCHRC. In any event, those one-time grants were not all made in fiscal 2012, and $1.4 million in funding was re-authorized and spent in fiscal 2013.

Issues

1. Implementation of Health Enterprise Zones

The creation of health enterprise zones (HEZ) was among the recommendations of the Health Disparities Workgroup under the Maryland Health Quality and Cost Council. Specifically, that workgroup recommended the creation of HEZs modeled after the Harlem Children's Zone and Promise Neighborhood programs to reduce health and health care disparities, improve outcomes, and stem the rise in health care costs. In HEZs, community-based organizations apply for funds specifically to improve health in a zone. A zone can be designated using various criteria including high rates of chronic disease, health disparities, and a lack of access to primary care.

As established in Chapter 3 of 2012, additional parts of the HEZ model include access to the Loan Assistance Repayment Program to support existing and new primary care clinicians in an HEZ; income, property, and/or hiring tax credits; assistance for health IT; priority to enter the State's patient centered medical home program; other grant funding from MCHRC; facility and capital equipment grants; and other medical practice expenses. Ultimately, the goal of an HEZ is to work with existing providers, insurers, the public health system, nonmedical community agencies, and other stakeholders to create an integrated health care system with improved health care access.

Implementation of HEZs in Maryland: Eligibility Criteria

In August 2012, following a public participation and comment process, DHMH and MCHRC submitted a report to the budget and relevant policy committees that defined criteria for consideration as an HEZ. These criteria are as follows:

- HEZs must be a contiguous geographic area defined by zip code boundaries and contain at least 5,000 people (although DHMH and MCHRC entertained applications from sub-zip code areas as long as they are contiguous and meet the 5,000 person threshold);

- HEZs must be economically disadvantaged based on relative participation in the Medicaid or federally funded health and nutrition program for women, infants, and children programs; and

- HEZs must demonstrate poor health outcomes based on relative life expectancy or the percentage of low-birth-weight infants.

If an HEZ is composed of multiple zip codes, each of the zip codes in that HEZ must meet the economic and health eligibility criteria.

There are an estimated 609 zip codes in Maryland. Of these, as shown in **Exhibit 8**, 105 meet the eligibility criteria. It should be noted that many zip codes overlap jurisdictional boundaries and are indicated as such in the exhibit. An estimated 267 zip codes fail to meet the basic population

Exhibit 8
Health Enterprise Zones – Number of Eligible Zip Codes by Jurisdiction

Jurisdiction (Number of Eligible Zip Codes)	Eligible U.S. Postal Service Zip Codes
Allegany (2)	21502 and 21532
Anne Arundel (15)	**20640**, **20707**, 20711, **20724**, 20755, 21060, 21061, 21144, **21208**, **21218**, **21224**, **21225**, **21226**, **21237**, and 21401
Baltimore City (30)	**21201**, **21202**, **21205**, **21206**, **21207**, **21208**, **21211**, **21212**, **21213**, **21214**, **21215**, **21216**, **21217**, **21218**, **21219**, **21220**, **21221**, **21222**, **21223**, **21224**, **21225**, **21226**, **21227**, **21229**, **21230**, **21231**, **21234**, **21237**, **21239**, and **21244**
Baltimore County (31)	21117, 21133, **21201**, **21202**, **21205**, **21206**, **21207**, **21208**, **21211**, **21212**, **21213**, **21214**, **21215**, **21216**, **21217**, **21218**, **21219**, **21220**, **21221**, **21222**, **21223**, **21224**, **21225**, **21227**, **21229**, **21230**, **21231**, **21234**, **21237**, **21239**, **21244**
Calvert (1)	20678
Caroline (3)	21629, **21632**, and 21655
Carroll (1)	**21787**
Cecil (5)	21901, 21903, 21904, 21911, and 21921
Charles (5)	**20601**, 20602, 20616, **20640**, and 20695
Dorchester (3)	21613, **21632**, and 21643
Frederick (4)	21702, **21787**, 21788, and 21793
Garrett (1)	21550
Harford (3)	21001, 21040, and 21078
Howard (3)	**20707**, **20724**, and 21045
Kent (1)	**21620**
Montgomery (9)	**20707**, 20851, 20866, 20874, 20879, 20886, **20903**, **20904**, and **20912**
Prince George's (25)	**20601**, **20640**, 20705, 20706, **20707**, 20708, 20710, 20712, 20722, **20724**, 20737, 20743, 20745, 20746, 20747, 20748, 20770, 20781, 20782, 20783, 20784, 20785, **20903**, **20904**, and **20912**
Queen Anne's (1)	**21620**
Somerset (3)	21817, **21851**, and 21853
St. Mary's (2)	20634 and 20653
Washington (2)	21740 and 21795
Wicomico (3)	21801, **21804**, and 21875
Worcester (3)	**21804**, 21842, and **21851**

Note: Zip codes can overlap multiple jurisdictions. Zip codes listed for two or more jurisdictions are shown in **bold**.

Source: Department of Health and Mental Hygiene; Maryland Community Health Resources Commission

threshold. As such, it is difficult to determine if these zip codes meet the economic and/or health eligibility criteria. Applications may be made for these zip codes in combination with adjacent zip codes, and DHMH will have to determine eligibility on a case-by-case basis.

Two observations can be made from Exhibit 8:

- With the exception of Talbot County, there is clear opportunity for the development of HEZs in every jurisdiction in the State.

- In many instances, because zip codes are not contiguous with jurisdictional boundaries, there were opportunities for applications from more than one jurisdiction. Ultimately, of those HEZs initially chosen, a multi-jurisdictional approach was only found in one. Not surprisingly, it was on the Eastern Shore where multi-jurisdictional approaches tend to be more common.

Implementation of HEZs in Maryland: Review Criteria

The same August 2012 report also established the criteria that will be used to review HEZ applications. These criteria include description of need; targets for improvement; measurable goals; strategies for meeting goals; ensuring cultural competence; contributions from local partners; the breadth of the coalition supporting the application; work plan; program management; sustainability; and evaluation and progress monitoring.

DHMH and MCHRC made a full list of outcomes by zip code available to applicants to assist in the development of applications. Clearly, since applicants have to demonstrate measurable progress toward identified goals, the availability of data at the HEZ level is critical. While the application noted that the goal setting has a target date of 2016, incremental progress and specific processes identified to achieve goals is part of the internal monitoring and review process. DLS would note that although the review criteria are silent on this issue, external independent review would also be valuable.

Implementation of HEZs in Maryland: Financing and Awards

As initially envisioned by DHMH and MCHRC, it was anticipated that two to four HEZs would be designated under this initiative, and that a total of $4 million per year will be made available to the designated HEZs beginning in calendar 2013 and provided for a four-year period. Funding beyond calendar 2013 will be contingent on continued progress in meeting performance standards and evaluation measures agreed to as a requirement for receiving the award. Beyond calendar 2016, an HEZ is required to develop alternative funding sources; reporting on sustainability goals is also required during the four-year grant period.

Ultimately, five HEZs were designated as shown in **Exhibit 9**. More detailed budget proposals for the full four-year period are noted in **Exhibit 10**.

Exhibit 9
Calendar 2013 HEZs

Recipient	Brief Description	Targeted Conditions	Funding 2013/2013-2016
Dorchester County Health Department	Addition of 18 new health care providers and creation of a new mobile mental health crisis team in Dorchester and Caroline counties.	Diabetes, hypertension, and behavioral health issues	$775,000/$3,020,000
Medstar – St. Mary's Hospital	Creation of a new community health center in Lexington Park to include adding 8 new health care providers.	Asthma, diabetes, cardiovascular diseases, and behavioral health conditions	$750,000/$3,000,000
Prince George's County Health Department	Creation of five new patient centered medical homes in Capitol Heights including the addition of 25 new health care providers.	Cardiovascular, respiratory and cerebrovascular diseases, diabetes, and low birth weight infants	$1,100,000/$4,400,000
Bon Secours Hospital	Expand access to primary and preventive care in West Baltimore through the addition of 18 primary care health providers and the creation of a community health infrastructure through the deployment of 11 community health workers.	Cardiovascular disease	$1,050,000/$4,200,000
Anne Arundel Medical Center	Creation of a patient centered medical home with 4 health care providers located within Morris Blum public housing in Annapolis.	Birth outcomes, diabetes, and hospital utilization	$200,000/$800,000

HEZ: health enterprise zone

Note: Although one recipient is noted, each HEZ has multiple coalition partners.

Source: Maryland Community Health Resources Commission

Exhibit 10
Calendar 2013-2016 HEZ Budget Details

	Dorchester		Medstar – St. Mary's Hospital		Prince George's County Health Department		Bon Secours		Anne Arundel Medical Center	
	HEZ Grant	Other Resources	HEZ Grant	Other Resources	HEZ Grant	Other Resources	HEZ Grant	Other Resources	HEZ Grant	Other Resources
State Tax and Hiring Credits	$240,000		$150,000		$394,600		$260,000			
Data Collection	212,000		118,000		329,700		408,300			
Capital/Leasehold Improvements			240,000		750,000					
Grant Funding for Other Purposes	2,568,000		2,492,000		3,085,279		3,531,700		$800,000	
Loan Repayment Assistance		$275,000		$400,000		$480,000		$800,000		$120,000
Other		1,964,000								
Total	**$3,020,000**	**$2,239,000**	**$3,000,000**	**$400,000**	**$4,559,579**	**$480,000**	**$4,200,000**	**$800,000**	**$800,000**	**$120,000**

HEZ: health enterprise zone

Source: Maryland Community Health Resources Commission

A number of points can be raised about the HEZs chosen:

- The Loan Assistance Repayment Plan program payments are considered outside of the grant payments from MCHRC. These payments are projected to total almost $2.1 million between calendar 2013 and 2016 and will be supported by MHEC. This is different from the information provided to the legislature when the HEZ legislation was being considered. At that time, all HEZ incentives were considered to be from the MCHRC funding. However, four of the five HEZs (all but the Anne Arundel Medical Center project) are in areas already eligible for LARP by being in designated Health Professional Shortage Areas (HPSA). DHMH is negotiating with the U.S. Health Resources and Services Administration to get HPSA designation for the fifth HEZ.

- Dorchester County's overall budget includes almost $2.0 million identified as other resources. This is funding from the Mental Hygiene Administration to support a mobile crisis team in Calendar 2013 and through 2016.

- The $4.6 million in funding for Prince George's County noted in Exhibit 10 exceeds the $4.4 million in funding identified in Exhibit 9. Prince George's County is in the process of revising its 4-year budget to fit within the $4.4 million available funding.

- The Bon Secours proposal includes $168,000 over four years for indirect costs. This is the only proposal that includes any allowance for indirect costs, although indirect costs up to 10% of total grant award are permitted.

- Tax credits play an important role in four of the HEZs, totaling over $1.0 million in the four-year period. The general fund is supposed to be reimbursed for the cost of these tax credits, and the mechanism for doing so will be outlined in forthcoming regulations.

- Data collection and evaluation is an important part of the HEZs overall budget, with expenditures estimated at $1.1 million over four years. All HEZs are required to submit a data tracking and monitoring plan that will include clinical outcome goals and the methodology for calculating baseline measurements. Progress towards meeting key goals is supposed to be a determinant for ongoing funding.

Conclusion

DLS would also note that because the HEZ pilot will now be financed for calendar 2013 through 2016, the implementing statute should be amended to clarify that the HEZ pilot will run for four calendar years rather than the four fiscal years specified in Chapter 3, and also that tax benefits will be available for the full four-year period as opposed to through tax year 2015 as currently stated in Chapter 3 of 2012.

Recommended Actions

		Amount Reduction	
1.	Reduce funding for the Small Employer Health Premium Subsidy. With the opening of the Maryland Health Benefit Exchange on January 1, 2014, and the significant federal tax benefits that will be available to small businesses obtaining health insurance through the exchange, the Small Employer Health Premium Subsidy can be eliminated after January 1, 2014. If adopted, a separate action to reduce the general fund appropriation for the Medicaid program by a like amount can be taken to utilize the available special funds.	$ 1,000,000	SF
	Total Special Fund Reductions	**$ 1,000,000**	

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Health Regulatory Commissions
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2012					
Legislative Appropriation	$0	$162,560	$3,314	$285	$166,158
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	0	-874	883	6,184	6,193
Reversions and Cancellations	0	-5,856	-313	-1,393	-7,562
Actual Expenditures	**$0**	**$155,830**	**$3,885**	**$5,075**	**$164,789**
Fiscal 2013					
Legislative Appropriation	$0	$162,052	$2,800	$100	$164,952
Budget Amendments	0	88	0	1,383	1,471
Working Appropriation	**$0**	**$162,140**	**$2,800**	**$1,483**	**$166,424**

Note: Numbers may not sum to total due to rounding.

Fiscal 2012

The fiscal 2012 legislative appropriation for the Health Regulatory Commissions was reduced by $1.4 million. This decrease was derived as follows:

- Budget amendments added just under $6.2 million to the legislative appropriation. Specifically:
  - Special funds were reduced by $874,000. This reduction was driven by lower than anticipated Uncompensated Care Fund expenditures ($972,000) that was partially offset by increases associated with the funding of the fiscal 2012 one-time $750 bonus ($67,000) and in grant funding for regional meetings as part of the State Health Improvement Plan process ($32,000).
  - The reduction in special funds was more than offset by an increase in federal funds of $883,000, all related to health IT activities.
  - Similarly, the appropriation was increased by reimbursable fund budget amendments totaling almost $6.2 million. Over $6.0 million of this funding was received from the DDA for the award of one-time grants to be made by the MCHRC. At the time of the transfer, these funds were believed to be surplus to funding requirements for DDA's ongoing community services programs. As discussed in the DDA analysis, DDA ended the fiscal 2012 with a significant deficit.
- Cancellations more than offset the increase to the legislative appropriation derived from budget amendments, reducing the appropriation by almost $7.6 million. Of this, $5.9 million was special funds primarily related to lower than anticipated Uncompensated Care grants through the HSCRC ($4.3 million) and lower than anticipated spending in a variety of areas in MHCC ($974,000). Other significant cancellations included $1.4 million of the reimbursable funding that had been transferred to MCHRC from DDA for one-time grants noted above.

Fiscal 2013

To date, the fiscal 2013 legislative appropriation for the Health Regulatory Commissions has been increased by just under $1.5 million, $88,000 in special funds to support the fiscal 2013 COLA and the reappropriation of the $1.4 million in funding from DDA to MCHRC for one-time grants and to support a part-time auditor to monitor the grants.

Appendix 2

Audit Findings

Audit Period for Last Audit:	May 1, 2008 – May 15, 2011
Issue Date:	January 2013
Number of Findings:	5
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Note: The audit is of all three commissions but findings are specific to one or other commission.

Finding 1: HSCRC did not have a process to determine if hospital billing systems were accurately maintained to provide assurance that billing rates were in accordance with HSCRC's rate orders. HSCRC concurred with the finding and related recommendations.

Finding 2: HSCRC did not adequately investigate the impact of hospital billing overcharges identified through annual agreed-upon procedures. HSCRC concurred with the finding and related recommendations. It should be noted that OLA made one recommendation regarding adjusting future rates to account for overcharging, requiring repayment of specific overcharges, and/or assessing penalties. The HSCRC response to this particular recommendation, while agreeing, also noted that one specific hospital that was noted as overcharging was in fact charging appropriately. OLA subsequently noted that this particular billing error was actually disclosed during a 2009 review and not investigated by the HSCRC until OLA drew attention to it during the audit, underscoring OLA's contention that the HSCRC was not adequately investigating overcharges.

Finding 3: HSCRC did not periodically review documentation to support the reasonableness of billed unit levels assigned by hospitals for certain medical procedures. HSCRC concurred with the finding and related recommendations.

Finding 4: The calculations used to determine the annual hospital rate orders were not independently reviewed by supervisory personnel. HSCRC concurred with the finding that this review was not documented but maintained that the review did occur.

Finding 5: MHCC did not require its contactor to comply with State law and its contract by confirming that trauma patients on reimbursement claims were listed on the Maryland Trauma Registry. MHCC concurred with the finding and related recommendations.

Object/Fund Difference Report
DHMH – Health Regulatory Commissions

Object/Fund	FY 12 Actual	FY 13 Working Appropriation	FY 14 Allowance	FY 13 - FY 14 Amount Change	Percent Change
Positions					
01 Regular	98.70	98.70	98.70	0.00	0%
02 Contractual	0.00	0.35	0.00	-0.35	-100.0%
Total Positions	**98.70**	**99.05**	**98.70**	**-0.35**	**-0.4%**
Objects					
01 Salaries and Wages	$ 9,461,823	$ 10,431,025	$ 11,095,670	$ 664,645	6.4%
02 Technical and Spec. Fees	26,626	38,177	37,541	-636	-1.7%
03 Communication	82,704	88,813	86,879	-1,934	-2.2%
04 Travel	87,028	96,979	110,934	13,955	14.4%
08 Contractual Services	144,734,488	144,797,350	153,656,716	8,859,366	6.1%
09 Supplies and Materials	84,780	75,404	79,424	4,020	5.3%
10 Equipment – Replacement	160,120	41,000	40,800	-200	-0.5%
11 Equipment – Additional	8,052	47,303	56,200	8,897	18.8%
12 Grants, Subsidies, and Contributions	9,788,781	10,373,240	10,273,314	-99,926	-1.0%
13 Fixed Charges	354,841	434,523	447,647	13,124	3.0%
Total Objects	**$ 164,789,243**	**$ 166,423,814**	**$ 175,885,125**	**$ 9,461,311**	**5.7%**
Funds					
03 Special Fund	$ 155,829,536	$ 162,140,437	$ 174,958,365	$ 12,817,928	7.9%
05 Federal Fund	3,884,507	2,800,000	926,760	-1,873,240	-66.9%
09 Reimbursable Fund	5,075,200	1,483,377	0	-1,483,377	-100.0%
Total Funds	**$ 164,789,243**	**$ 166,423,814**	**$ 175,885,125**	**$ 9,461,311**	**5.7%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Health Regulatory Commissions

Program/Unit	FY 12 Actual	FY 13 Wrk Approp	FY 14 Allowance	Change	FY 13 - FY 14 % Change
01 Maryland Health Care Commission	$ 31,978,677	$ 31,938,159	$ 31,336,487	-$ 601,672	-1.9%
02 Health Services Cost Review Commission	125,063,704	126,100,176	136,543,241	10,443,065	8.3%
03 Maryland Community Health Resources Commission	7,746,862	8,385,479	8,005,397	-380,082	-4.5%
Total Expenditures	**$ 164,789,243**	**$ 166,423,814**	**$ 175,885,125**	**$ 9,461,311**	**5.7%**
Special Fund	$ 155,829,536	$ 162,140,437	$ 174,958,365	$ 12,817,928	7.9%
Federal Fund	3,884,507	2,800,000	926,760	-1,873,240	-66.9%
Total Appropriations	**$ 159,714,043**	**$ 164,940,437**	**$ 175,885,125**	**$ 10,944,688**	**6.6%**
Reimbursable Fund	$ 5,075,200	$ 1,483,377	$ 0	-$ 1,483,377	-100.0%
Total Funds	**$ 164,789,243**	**$ 166,423,814**	**$ 175,885,125**	**$ 9,461,311**	**5.7%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.